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Psychopathology, coping strategy and Emotional Intelligence among Battered Women

Priya Jadav

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INTRODUCTION

This chapter provides a brief description of battered women syndrome and all the variables under study such as the concept of marriage and marital adjustment in battered women, psychopathology related to the syndrome and the commonly adopted coping strategies by the battered women.

Concept of marriage:

Marriage is a 'the process during which partners in a marriage adapt and change to their new roles complementing each other acting as a team opposed to two separate units, it is also important to unify the following- interests and values, maintaining open line s of communication and encouraging the expression of each others communication.' "Shortly after 'tying the knot' the new couple will enter into marital adjustment where they will establish their place within the relationship found their feet in the new life."(Lively 1969; Donohue and Ryder 1982; Trost 1985)

Marital adjustment:

Marital adjustment has been defined as "the integration of the couple in a union in which the two personalities are not merely merged, or submerged, but interact to complement each other for mutual satisfaction and the achievement of common objectives" (p. 10).Scientists have long been interested in understanding which factors contribute to success in marriage and which to failure. As early as the 1920s, Gilbert Hamilton (1929) conducted research on marital satisfaction by using thirteen clusters of questions. In 1939, Burgess &Cottrell published Predicting Success or Failure in Marriage, in which they systematically discussed marital adjustment.

Researchers have not agreed upon the use of any one term. To describe the seemingly same phenomenon, some have used the terms "marital quality," "marital satisfaction", and "marital happiness." Lewis & Spanier have defined marital quality as "a subjective evaluation of a married couple's relationship" (1979)—a concept similar to that of "marital adjustment." There have been numerous definitions of "marital adjustment" and "marital quality" (Spanier & Cole 1976), and it may not be fruitful to attempt to define the concept in a sentence or two. Rather, the following description of the factors that constitute marital adjustment or quality may prove more meaningful.

Since Burgess and Cottrell's formulation, scientists have examined extensively the factors constituting marital adjustment. Although there has been no consensus among researchers, factors constituting marital adjustment include agreement, cohesion, satisfaction, affection, and tension. Agreement between spouses on important matters is critical to a well-adjusted marriage. Though minor differences may broaden their perspectives, major differences between the spouses in matters such as philosophy of life, political orientations, and attitudes toward gender roles are detrimental to marital adjustment. In addition, agreement on specific decisions about family matters must be reached in good accord. Marital cohesion refers to both spouses' commitment to the marriage and the companionship experienced in it. In a well- adjusted marriage, both spouses try to make sure that their marriage will be successful. They also share common interests and joint activities. In a well-adjusted marriage, both spouses must be satisfied and happy with the marriage. Unhappy but long-lasting marriages are not well-adjusted ones. Spouses in well-adjusted marriages share affection, and it is demonstrated as affectionate behavior. Finally, the degree of tension in a well-adjusted marriage is minimal, and when tension arises it is resolved amicably, probably in discussion, and the level of tension and anxiety is usually low.

The core component of marital adjustment is marital satisfaction, and it has been extensively studied as a stand-alone concept. As such, it deserves separate consideration. Marital satisfaction has been defined as: "the subjective feelings of happiness, satisfaction, and pleasure experienced by a spouse when considering all current aspects of his marriage. This variable is conceived as a continuum running from much satisfaction to much dissatisfaction. Marital satisfaction is clearly an attitudinal variable and, thus, is a property of individual spouses." (Hawkins 1968, p. 648). In the present study, an attempt was made to explore the level of marital adjustment and its relationship with battered women syndrome's psychopathology and coping strategies.

Battered Women Syndrome:

Battered women syndrome consists of multiple episodes wherein a woman is physically assaulted by the partner or people with whom she has relationship causing physical and psychological disturbance or trauma. Such violence tends to follow a predictable pattern. The violent episodes usually follow verbal argument and accusation and are accompanied by verbal abuse. Almost any subject-housekeeping, money, childrearing-may begin the episode.

Over time, the violent episodes escalate in frequency and severity. Most battered women report that they thought the assaults would stop; unfortunately, the longer the women stay in the relationship the more likely they are to be seriously injured. Less and less provocation seems to be enough to trigger an attack once the syndrome has begun. (Walker 1970)

Battered woman syndrome occurs at all socioeconomic levels, and one half to three quarters of female assault victims are the victims of an attack by a partner. Men who grew up in homes in which the father abused the mother are more likely to beat their wives than are men who lived in nonviolent homes. Personal and cultural attitudes also affect the incidence of battering. Aggressive behaviour is a normal part of male socialization in most cultures; physical aggression may be condoned as a means of resolving a conflict.

It's important to understand this, as victims often blame themselves for being battered when it is never their fault – no matter what the batterer says. It has been observed that the use of alcohol may increase the severity of the assault. The man is more likely to be abusive as the alcohol wears off. Battering occurs in cycles of violence. In the first stage the man acts increasingly irritable, edgy, and tense. Verbal abuse, insults, and criticism increase, and shoves or slaps begin. The second stage is the time of the acute, violent activity. As the tension mounts, the woman becomes unable to placate the man, and she may argue or defend herself. The man uses this as the justification for his anger and assaults her, often saying that he is "teaching her a lesson." The third stage is characterized by apology and remorse on the part of the man, with promises of change. The calm continues until tension builds again.

In general, a pattern has been followed during battered women syndrome. There are three phases identified by (Walker 1984):tension building phase, wife battering episode and a "honeymoon" phase where there is a respite which has been further explained below.

During the tension building phase, the wife often "walks on eggshells" around her batterer and is aware of the fact that the tension is building. Little things may make the batterer mad such as a meal he doesn't like or his wife being late. These minor infractions produce unreasonable tension in the relationship. This tension eventually explodes in an acute wife battering episode. The battering may be a more minor push or slap or may be a major beating leading to broken bones or worse. The batterer may prevent the victim from receiving

healthcare for their injuries and threaten the victim or others if the victim threatens to tell anyone about the abuse. Once the acute battering is over, the batterer often tries to charm his way out of what has happened; promising to never to do it again and attempting to make amends by doing things like buying flowers and being extra attentive. Typically though, the wife batterer has no intention of stopping and is simply trying to manipulate the victim into not telling others, believing "it's not that bad," and that it's "all in her head."

Victims of the battered woman syndrome are often afraid to leave the man and the situation; change, loneliness, and the unknown are perceived as more painful than the beatings.A personality profile obtained by psychological testing reveals that the typical battered woman are found to be reserved, withdrawn, depressed, and anxious, with low self-esteem, a poorly integrated self-image, and a general inability to cope with life's demands(Walker 1984). The parents of such women encouraged compliance, were not physically affectionate, and socially restricted their daughters' independence, preventing the widening of social contact that normally occurs in adolescence. (Goolsby, 1985)

In India, a battered wife may stay in a relationship for a variety of reasons such as: they feel that the abuse isn't "real," or "isn't that bad", they think they can change the abuser, believe it will never happen again, Believe that help won't work or that no one will believe them or that they deserve the abuse. The most common reason explored is that the battered women don't want to break up a family and thus stay with a batterer because she feels sorry for him as he often comes from a history containing abuse. The other factors are that the battered women are economically and psychologically dependent on the batterer and are afraid to leave, are afraid for the welfare of others (like their children) (Walker 1970).

Battered Women: Depression

Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration.

It can be long lasting or recurrent, substantially impairing a person’s ability to function at work or school, or cope with daily life. At its most severe, depression can lead to suicide.

When mild, depression can be treated without medicines but, when moderate or severe, people may need medication and professional talking treatments.

Non-specialists can reliably diagnose and treat depression as part of primary health care. Specialist care is needed for a small proportion of people with complicated depression or those who do not respond to first-line treatments. Depression often starts at a young age. It affects women more often than men.(Rollins and Cannon 1974).

Battered Women: Emotional Intelligence

Emotional intelligence has been defined as 'the capacity to reason about emotions, and of emotions to enhance thinking.' It includes the abilities to accurately perceive emotions, to access and generate emotions so as to assist thought, to understand emotions and emotional knowledge, and to reflectively regulate emotions so as to promote emotional and intellectual growth (Mayer, Caruso, & Salovey, P., 1999).

Battered Women: Stress

Stress is your body's way of responding to any kind of demand. It can be caused by both good and bad experiences. When people feel stressed by something going on around them, their bodies react by releasing chemicals into the blood. These chemicals give people more energy and strength, which can be a good thing if their stress is caused by physical danger. But this can also be a bad thing, if their stress is in response to something emotional and there is no outlet for this extra energy and strength. This class will discuss different causes of stress, how stress affects you, the difference between 'good' or 'positive' stress and 'bad' or 'negative' stress, and some common facts about how stress affects people today. (Zletnick (2009)

Stress and Coping Strategies in Battered Women:

Everyone faces stress at some time in life. There are physiological changes that occur when you face perceived threats in certain situations. These situations are known as stressors. When your stress response is triggered, a series of changes occur within your body. These changes can include: an increased pulse, the release of adrenaline, redirection of blood toward major organs, and the release of cortical and other hormones. This response was helpful to our ancestors, especially in fighting off attackers or running away from threats. Today, the stress response can actually hurt you if it becomes chronic stress, which is when

the stress response isn't stopped by the body's relaxation response. This is where coping strategies, or a conscious effort to solve a personal or interpersonal problem that will help in overcoming, minimizing, or tolerating stress or conflict, come in - we need ways to calm our minds and bodies after a stressor has taken its toll. The two main categories of coping strategies are *emotion-focused coping and solution-focused coping*(Burr et al. 1979).

Battered Women: Post Traumatic Stress Disorder:

A psychological reaction occurring after experiencing a highly stressing event (as wartime combat, physical violence, or a natural disaster) that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event — abbreviation *PTSD* —called also post-traumatic stress syndrome(Cuber, 1986).

Overall, it could be inferred that the battered women syndrome is a traumatic condition wherein the women feels helpless and uses various coping strategies to deal with it. Thus, the present study attempted to explore the relationship between marital adjustment, psychopathology and coping strategies in battered women.

LITERATURE REVIEW

The following chapter reviews and explains the past studies related to the present topic and also briefly outlines the rationale behind the present study.

Victims of Domestic violence:

Family victimization is a national crisis for women and children. These victims may be immobilized and rendered helpless, with an attendant loss of self-respect, but often they suffer much more serious consequences. Family victims are characteristically "trapped, cornered, or overpowered, physically or psychologically, and they cannot function" (Boss, 2002,). The impacts of being battered include high rates of medical problems, head and neck injuries, broken bones, contusions, abrasions, lacerations, miscarriages, depression, and suicide attempts. (Hamberger& Phelan, 2004; Roberts, 2006). Victim's symptoms can include persistent acute and chronic re-experiencing of the traumatic events of victimization, persistent symptoms of physical and emotional arousal, and avoiding stimuli associated with the trauma through a numbing of general responsiveness – often facilitated through the abuse of alcohol and other substances. All of these can seriously impair the individual's functioning. Females suffering from battered woman syndrome often meet the same DSM-IV (2000) diagnostic criteria for post- traumatic stress disorders (PTSD) as do veterans returning from foreign wars.

Many victims of domestic violence are dually diagnosed with PTSD and substance dependence (SD): "The literature is clear that there is a strong link between victimization or traumatization in women and substance abuse and dependence disorders." (Covington, Burke, Keaton, & Norcott, 2008, p. 388). Both PTSD and SD are associated with increased rates of self-harm, suicidal ideation, and suicide attempts. (Harned, Najavits, & Weiss, 2006).

Victims of domestic violence predict and often accompany involvement in the criminal justice system. A significant body of research shows that women who are jailed reported elevated rates of physical, emotional, and sexual abuse, particularly abuse as children. (Green, Miranda, Daroowalla, & Siddique, 2005). The criminal justice system is philosophically predisposed to addressing issues characteristic of male criminal offenders. It is not adequate to serving these women who find themselves incarcerated – often for drug

possession of related offenses. Substance abuse itself leads to a number of risky behaviors beyond criminality, including the transmission of AIDS and other sex related diseases. Since a majority of these incarcerated women are mothers, this has profound social implications. Investigation suggests that children benefit from treatment programs that target mothers who are abused. (McFarlane, Groff, O'Brien, & Watson, 2005).

As observed by Roberts (2006, p. 521) using survey information provided by Tjaden and Thoennes (2000), "family violence is a prevalent, dangerous, and often life-threatening social and public health problem. It is an indiscriminating crime that knows few boundaries, as recent annual estimates indicate that over 8.7 million women are battered by husbands, boyfriends, and other intimate partners." This translates to a woman being battered, in the United States alone, by someone she knows on average once every nine seconds.

The literature assumes that governmental statistics and estimates are unreliable because of privacy issues that result in an under-reporting of the true numbers, or victim's fears of retaliation, "as well as lost police records due to computer crashes." (Roberts, 2006, p. 521). Many women never make police reports and may stay in battering relationships for extended periods. All of this is the so-called "dark figure" of domestic violence. This is likely the case when we speak to statistics relating to family and intimate partner violence.

Domestic Violence and PTSD

In 2001 Jones, Hughes and Untersaller undertook a review of the academic literature concerning PTSD syndrome for women as a result of the domestic violence these women had encountered. Their broad conclusions (p. 100) include the following:

- The symptoms shown by battered women are consistent with the major indicators of PTSD as currently defined by the DSM-IV. Findings across varied samples including shelters, hospitals, and community agencies is that 31% to 84% of victimized women exhibit PTSD symptoms.
- The domestic violence shelter population is at higher risk for PTSD than those similarly victimized women who are not in shelters, with estimates ranging from 40% to 84% of the shelter population.

- Having multiple victimizations over time (childhood abuse, especially sexual abuse, and adult sexual abuse) increases the likelihood of PTSD and other psychiatric disorders.
- The extent, severity, and type of abuse is connected with the intensity of PTSD. The more life threatening the abuse, the more traumatic the effects. Women need not experience severe violence to suffer PTSD symptoms, but experiencing severe violence exacerbates symptoms. Psychological abuse may be as damaging as physical abuse.
- Depression and dysthymia in particular tend to accompany PTSD victims of domestic violence.
- Suicide is a risk for domestic violence victims of display PTSD symptoms.
- In a high percentage of victimized women, substance abuse was reported. Women who reported being victims of child abuse and adult victimization had significantly more lifetime drug and alcohol dependence than women not reporting abuse.
- Younger, unemployed women with a relatively large number of children, low income, and poor levels of social support are more at risk for experiencing PTSD symptoms.

Treatments exist for persons in the acute aftermath of trauma; however, traditional treatment responses to PTSD have been criticized by some as being contraindicated for battered women, especially women in shelters. (Johnson & Zletnick, 2009). The first-line treatments for trauma victims suffering PTSD are primarily exposure-based. Since battered women in shelters have multiple safety concerns that can lead to increased anxiety (e.g., homelessness, children, risks of re-victimization), such anxiety if overwhelming can impede the efficacy of these techniques in this population of PTSD sufferers.

Johnson and Zletnick (2009) have proposed one treatment model using cognitive-behavioral theories. They have developed “HOPE” for treating PTSD in battered women in shelters, an acronym for Helping to Overcome PTSD through Empowerment. HOPE was designed for battered women with ongoing safety concerns; however, Johnson and Zletnick (2009) warn that “HOPE is unsuitable for women with significant pathology (i.e., sociality, a bipolar or psychotic disorder, and/or active substance dependence) who need more intensive and specialized treatment.” Hence, there is no HOPE for dual diagnosis victims. This is

unfortunate since the literature strongly supports conclusions of a nexus between drug and alcohol abuse and the stress of domestic violence. (Eby, 2004).

Effects and Characteristics of Co morbid PTSD and Substance Abuse

There is a long established correlation between women with PTSD and SD with self-harm and suicidal behavior. Harned et al. (2006) postulate that "individuals with comorbid PTSD and SD may be at high risk for self-harm and suicidal behavior. Indeed, two studies have found that women with this dual diagnosis report a higher number of lifetime suicide attempts than women with either PTSD or SD alone" (p. 392). Their findings were that twenty-one percent of the women in their sample with comorbid PTSD and SD had engaged in self-harm behavior in the past three months, a rate comparable to life-time prevalence rates of self-harm reported in studies of women with substance use disorders. The rate of suicide attempts in the prior three months was lower than previous studies of PTSD-SD patients, but these prior studies assessed life-time rather than recent suicide attempts. Their results also suggested that PTSD and SD were each perceived as contributing to self-harm and suicidal behavior. Almost 62 percent of the women who had made a suicide attempt and/or harmed themselves in the prior three months reported using alcohol or drugs immediately before or during the episode. "These findings are consistent with research indicating that self-harm and suicide attempts often regulate overwhelming internal experiences, such as unwanted emotions, flashbacks, and unpleasant thoughts" (p. 394).

Women who had not engaged in self-harming behaviors were more likely to report that concerns about children, a belief in their ability to cope, and a wish to survive helped them to stay safe (p. 395). Those results were consistent with the research indicating that similar reasons for living best differentiate suicidal and no suicidal groups.

Dual diagnosis of PTSD and SD dramatically increases the likelihood that women will become incarcerated within the criminal justice system. This has profound sociological implications since 70% of jailed women are mothers, and the consequences to these children are extremely negative. As Green et al. (2005, p. 341) note, according to U.S. Department of Justice statistics released in 2003, there has been a dramatic growth in the increase of the female population in the nation's jails, mostly attributed to increases in illicit drug use among women and an increase in drug related convictions and mandatory sentencing. Women

prisoners have been shown to have had a very high exposure to a variety of trauma experiences, most notably interpersonal violence including childhood physical and sexual abuse with some studies suggesting that this exposure may be as high as between 77% and 90%. (Battle, Zlotnick, Najavits, Gutierrez, &Winson, 2003, as cited by Green et al., 2005).

Domestic Violence and Marital Adjustment:

Marital adjustment has long been a popular topic in studies of the family, probably because the concept is believed to be closely related to the stability of a given marriage. Well-adjusted marriages are expected to last for a long time, while poorly adjusted ones end in divorce. Simple as it seems, the notion of marital adjustment is difficult to conceptualize and difficult to measure through empirical research. After more than half a century of conceptualization about and research on marital adjustment, the best that can be said may be that there is disagreement among scholars about the concept, the term, and its value. In fact, several scientists have proposed abandoning entirely the concept of marital adjustment and its etymological relatives (Lively 1969; Donohue and Ryder 1982; Trost 1985).

Researchers have not agreed upon the use of any one term. To describe the seemingly same phenomenon, some have used the terms marital quality, marital satisfaction, and marital happiness. Robert Lewis and Graham Spanier have defined marital quality as a subjective evaluation of a married couple's relationship (1979, p. 269)—a concept similar to that of marital adjustment. There have been numerous definitions of Marital adjustment and marital quality (Spanier and Cole 1976), and it may not be fruitful to attempt to define the concept in a sentence or two. Rather, the following description of the factors that constitute marital adjustment or quality may prove more meaningful.

The concept of family life cycle seems to have some explanatory power for marital adjustment. Researchers and theorists have found, however, that family life cycle is multidimensional and conceptually unclear. Once a relationship between a particular stage in the family life cycle and marital adjustment is identified, further variables must be added to explain that relationship—variables such as the wife's employment status, disposable income, and role strain between spousal and parental roles (Crohan 1996; Schumm and Bugaighis 1986). Furthermore, the proportion of variance in marital adjustment "explained" by the family's position in its life cycle is small, typically less than 10 percent (Rollins and Cannon

1974). In the case of our analysis above, it is only 3 percent for both husbands and wives. Thus, some scholars conclude that family life cycle has no more explanatory value than does marriage or age cohort (Spanier and Lewis 1980).

Domestic Violence anxiety and depression:

Most studies on violence against women indicate that:

- The perpetrators of violence against women are almost exclusively men;
- Women are at greatest risk of violence from men they know;
- Women and girls are the most frequent victims of violence within the family and between intimate partners;
- Physical abuse in intimate relationships is almost always accompanied by severe psychological and verbal abuse;
- Social institutions put in place to protect citizens too often blame or ignore battered women.

Domestic violence is not confined to any one socio-economic, ethnic, religious, racial or age group. It is an issue of increasing concern because it has negative effect on all family members, especially children. It has been found that children, who witness violence at home, manifest symptoms similar to those who are directly abused. Domestic violence and its consequences for the physical and psychological well-being of women and children have been recognized as an important public health problem (Krantz et al.,2002; Gracia,2004). Consequences of domestic violence, characterized by women's experience of physical, psychological, and sexual injury or threat are manifold. A significant number of studies consider domestic violence as risk factor for health problems, including injury and death (Forjuoh et al.,1998; Mezey et al.,1998; Fanslow et al,1998),consequences on pregnancy and newborns (Alkan et al.,2002; Martin et al.,1998;

Domestic Violence and depression

Existing research has substantiated that women who have been recently battered are depressed, but for developing both effective clinical and community interventions, understanding what factors are related to and lorpredict their psychological distress is necessary. Previous studies have established links between depression and self-esteem (Campbell, 1989;Cascardi& O'Leary, 1992), feelings of control and

powerlessness(Campbell, 1989; Walker, 1984), abuse sustained (Cascardi & O'Leary,2014), social support (Mitchell & Hodson, 1983) , relationship with the assailant (Walker, 1984), and income, employment, and education (Mitchell & Hodson, 1983; Walker, 1984).Thus, at any given period of time, both intra individual variables, such as self-esteem, and more contextual variables, such as social support, are related to battered women's depression. For preventive interventions, however, moving beyond a cross-sectional, co relational approach isneeded to consider long-term models predicting depression.

Rationale of the study:

Reviewing the past literature and studies, it was found that even though many studies have been conducted with regard to battered women syndrome and their perpetrators, only a few have addressed the mental health issue and adoption of specific coping strategies in Indian women suffering from intimate partner violence. Thus, the present study was carried out to explore and understand the quality of married life in terms of marital adjustment and its relationship to development of psychopathology in the battered women, specifically post traumatic stress disorder, depression, stress and anxiety and to find out the various coping strategies employed by these women to deal with their daily stressors following the domestic violence.

METHODOLOGY

This chapter outlines the aim, objectives, alternate hypothesis and sampling design, procedure employed for the present purpose of the study.

Aim

- To explore the level of psychopathology, emotional intelligence experienced by battered women and the various coping strategies employed to deal with them.

Objectives:

- To find the relationship between marital adjustment and emotional intelligence.
- To find the relationship between stress level & marital adjustment.
- To find the relationship between coping strategies and marital adjustment.
- To find the relationship between coping strategies and emotional intelligence.
- To find the relationship between psychopathology and marital adjustment.

Hypotheses:

- There will be significant relationship between marital adjustment & emotional intelligence.
- There will be significant relationship between marital adjustment & stress level.
- There will be significant relationship between marital adjustment & coping strategies.
- There will be significant relationship between marital adjustment & psychopathology.
- There will be significant relationship between coping strategies & Emotional intelligence.

Study Design:

Cross-sectional design was employed in the present study.

Sample:

Total number of participants selected for the purpose of present study was 30 participants recruited from Jyoti Sangh and Mahilasuraksavibhag, Apana bazaar, Ahmedabad Sampling technique used was purposive sampling.

Inclusion criteria:

- Age range of 18-45 years.
- Incident of physical abuse by partner in last 3 months.

Exclusion criteria:

- Any severe medical condition
- Mental retardation

Materials:

- **Socio Demographic Data Sheet**

It contains information about the socio-demographic variables like age, sex, education, marital status, religion, socioeconomic status and domicile of the subjects.

- **Beck Depression Inventory (Aaron T Beck**)

Beck Depression Inventory developed by Aaron T Beck (YEAR). Beck Depression Inventory indicates the presence of depressed mood. There are 21 items in this rating scale. The BDI takes 5-10 minutes to complete inventory. Responses are scored 0-3 corresponding to nil, mild, moderate or severe depressive symptomatology in the response. Alpha reliability coefficients range from .76 to .95 in psychiatric samples and from .73 to .92 in non-psychiatric samples was established. It has high test-retest reliability with correlation ranging from .48 to .86 with psychiatric patients and from .60 to .83 with non-psychiatric groups. The validity of the BDI in measuring the construct of depression has been extensively researched.

- **Ways of coping scale(folkman and lezaras)**

In addition to these 52 items, one coping behavior was kept as a single item that pertained to alcohol or drug use. This was extended to another four-item scale, along with one four-item scale concerning joking about the stressor (Carver et al., 1989, p. 280). Most of the above scales were found to have satisfactory psychometric properties, and evidence for validity is provided (cf. Carver & Scheier, 1993; Carver, Scheier, &Pozo, 1992).

Theoretically, five of the factors were established as sub dimensions of problem solving, and five more as subdimensions of emotional coping. This makes good sense, but requires a test of the two levels. A second-order factor analysis did not replicate this hypothesized structure (Carver et al., 1989, p. 274; see also Zeidner& Hammer, 1992).

- **Hamilton anxiety rating scale**

The Hamilton Anxiety Rating Scale is clinician-rated scale that is intended to provide an analysis of the severity of anxiety in adults, adolescents, and children. It is scored based upon the composite rating of fourteen individually evaluated criteria. The evaluator is instructed to assess the extent to which the patient displays the given criterion. Each item is scored independently based on a five-point, ratio scale. A rating of 0 indicates that the feeling is not present in the patient. A rating of 1 indicates mild prevalence of the feeling in the patient. A rating of 2 indicates moderate prevalence of the feeling in the patient. A rating of 3 indicates severe prevalence of the feeling in the patient. A rating of 4 indicates a very severe prevalence of the feeling in the patient. To implement the Hamilton Anxiety Rating Scale, the acting clinician proceeds through the fourteen items, evaluating each criterion independently in form of the five-point scale described above. Issues that arise when using Hamilton Anxiety Rating Scale (HAM-A) have to do with how the clinician interprets the results, changes in the classification of anxiety disorder, symptoms being assessed, and newer measurements that may be more suitable for the particular subject.

Clinician's administer HARS and may influence the subject by how they explain the question. Interpretation of the subject's response may also be hindered by the clinician even when methods are present to prevent interviewer biases.

Procedure:

The present study follows a cross-sectional study design. The total sample recruited for the present study was thirty battered women from Jyoti Sangh Trust and Mahila Suraksha Vibhag. Various standardised psychological tests were used to assess emotional intelligence, psychopathology and coping strategies: Emotional Intelligence scale, marital adjustment inventory, Beck Depression Inventory, Post traumatic stress disorder rating scale, Stress rating scale and Ways of coping scale.

Data was entered on the SPSS version 20 and was analysed by using appropriate statistical procedures. The results will be presented in the next chapter.

RESULTS

Analysis strategy

The data was analyzed using SPSS version 20.0. Initially, the frequencies, percentages, mean and standard deviation was computed for the socio-demographic details which are presented in Table 1. Then, the data was analyzed for raw scores and the mean and standard deviations for each dimensions were calculated which are presented in Table 2. Pearson's correlations were computed which are presented in Tables 3-8.

Table 1: Percentages, Mean and Standard deviations of socio-demographic details

S.No.	Dimensions	Percentages	Mean (SD)
1)	Age in years: 19-23	10%	30.03 (5.774)
	24-27	26.67%	
	28-31	20%	
	32-36	26.67%	
	37-41	16.67%	
2)	Education		
	Primary	45%	
	Secondary	35%	
	Higher secondary	20%	
3)	Marital Status: Married	100%	
4)	Age of marriage		
	1 to 5	45%	
	6 to 10	17%	
	11 to 15	38%	
5)	Financial status		
	Low		
	Middle	100%	
	Upper		
6)	Occupation		
	Home maker	100%	
	Employees		

	Self employees		
7)	Residential status:		
	Urban	100%	
	Rural		
8)	Family type		
	Nuclear	100%	
	Joint		

The socio-demographic table shows that majority of participants were within the age range of 24-27 years (26.67%) and 32-36 years (26.67%) followed by 28-31 years (20%), 37-41 years (16.67%) and 19-23 years (10%). The mean age was 30.03 and standard deviation was 5.774. All the participants in the present study were resided in urban city (100%).

Table 2 Mean and standard deviation of all the variables

S.NO	DIMENSIONS	MEAN	SD
1	Total score of depression (BDI)	19.63	6.37
2	Total score on Marital Adjustment	15.67	2.12
3 1	Confrontive type of coping	11.03	3.96
2	Distancing type of coping	10.63	3.35
3	Self -Controlling type of coping	13.70	3.20
4	Seeking Social Support type of coping	10.77	3.89
5	Accepting Responsibility type of coping	8.67	3.87
6	Escape-avoidance type of coping	17.50	2.96
7	Planful Problem solving type of coping	9.80	12.54
8	Positive Reappraisal type of coping	9.70	18.39
9	Total score on coping	91.80	16.86
6 1	Awareness of emotions	63.47	15.07
2	Self- control	56.40	15.00
3	Managing emotions	55.37	17.56

4	Empathy	53.43	14.41
5	Motivation	58.83	50.26
6	Handling Other's emotions	53.13	4.37
7	Total score on Emotional Intelligence	339.70	58.64
7	Total score on PTSD scale	22.43	4.69
8	Total score on Stress scale	192.73	58.63
9	Total score on Hamilton Anxiety Scale	16.70	4.69

Table 3: Pearson correlation between marital adjustment and emotional intelligence

Dimension		**Awareness of emotions**	**Self-control**	**Managing emotions**	**Empathy**	**Motivation**	**Handling other's emotions**	**Total score on emotions**
Total score on Marital Adjustment								
r	_	-.234	- .301	.206	-	-.014	.127	-.404
p	_	.213	.106	.286	.464	.939	.505	.819

***p<.01 significance level, *p<.05 significance level.*

No significant correlation between marital adjustment and emotional intelligence in battered woman syndrome.

Table 4: Pearson correlation between marital adjustment and stress

Dimension	
Marital adjustment	Stress
r	.062
p	.746

***p<.01 significance level, *p<.05 significance level.*

No significant correlation between marital adjustment and stress in battered women syndrome.

Table 5: Pearson correlation between marital adjustment and coping strategy

Dimensions	CC	DC	SC	SS	AR	EA	PPS	PR	Total
Marital adjustment									
r	.087	.919	-.145	.049	-.042	-285	-.256	-.116	-.179
p	.646	.312	.444	.797	.824	.127	.172	.543	.344

***p<.01 significance level, *p<.05 significance level.*

No significant correlation between marital adjustment and coping strategy in battered women syndrome.

Table 6: Pearson correlation between emotional intelligence and coping strategy

Dimensions	CC	DC	SC	SS	A	EA	PP	PR	TOTAL
AOE									
r	-.309	-.035	.121	-.036	-.144	-.022	.148	.238	-.116
p	.0906	.853	.525	.849	.448	.907	.435	.735	.541
SC									
r	-.355	.066	.074	.029	.277	.153	.171	.181	.161
p	.054	.728	.699	.878	.138	.419	.367	.337	.390
ME									
r	.009	.166	-.025	-.341	.097	-.303	.291	.039	-.030
p	.962	.380	.895	.065	.610	.104	.118	.838	.875
E									
r	-.015	.278	.068	-.213	-.120	-.184	-.111	-.064	-.096
p	.938	.137	.723	.258	.528	.331	.560	.737	.613
M									
r	-.022	-.039	-.123	.086	.043	-.276	.031	.258	-.053
p	.909	.837	.519	.650	.821	.139	.869	.169	.782
HOE									
r	-.053	.120	.050	-.263	.010	-.278	.067	.295	-.029
p	.782	.529	.795	.160	.958	.137	.724	.113	.877
TEI									
r	-.265	.228	.042	-.253	-.113	-.231	.150	.008	-.127
p	.157	.225	.824	.177	.553	.220	.427	.965	.505

***p<.01 significance level, *p<.05 significance level.*

No significant correlation between emotional intelligence and coping strategy in battered women syndrome.

Table : 7 Pearson correlation between marital adjustment and psychopathology

Dimension	PTSD	DEP	STRESS	ANXIETY
MA				
r	.120	-.127	.062	.132
p	.527	.504	.746	.488

***p<.01 significance level, *p<.05 significance level.*

No significant correlation between marital adjustment and psychopathology in battered women syndrome.

DISCUSSION

Socio demographic details

The present endeavour was carried out to explore the psychopathology, emotional intelligence, marital adjustment and the common coping strategies adopted by battered women. In particular, total thirty battered women were recruited for the purpose of present study and various questionnaires were administered for the same.

Urban settlement:

Looking at the socio-demographic details, it was observed that all the participants hailed from urban domicile (100%) because the sample was collected from urban city Ahmedabad, Gujarat.

Education:

It was also found that the majority of the participants were literate up to the primary level.

Marital age:

The mean age of the marriage was found to be indicating that the women were married during their young adulthood phase wherein they did not possess much knowledge about family settings, marital relationships, and child rearing practices etc. A study by Hamberger& Phelan (2004) found that overall, 75% of girls were married with a “much older” partner and experienced physical violence, 80% emotional violence and 75% sexual violence.

Type of family:

All the participants (100%) belonged to joint family setup wherein the value system is rigid. Specifically, in Gujarat, majority of the household are in joint setup wherein the women have to follow the traditions and folklores of the particular household setup and any deviation from it might lead to issues in marriage if the attachment is not strong between the husband and the wife.

Financial status:

It was mostly observed that none of the women were working as they lived in joint family and were liable to perform household chores rather than being employed in MNCs or government sector. Traditionally, it is seen that the women have been suppressed as the man is considered to be the earning member of the family. Specifically, in Gujarat, the patriarchal system is followed, thus the women are financially dependent on the male figures of home.

Marital adjustment:

In the present study, the mean marital adjustment score was found to be 15.67 indicating poor marital adjustment wherein the battered women had feelings of mistrust, insecurity and lack of understanding and attachment which are considered to be the core elements of a successful married life. A study by consistent with the findings of the present study. One hundred battered wives were interviewed. All had bruising, often together with other injuries, such as lacerations and fractures, There was a high incidence of violence in the family histories of both partners, and of drunkeness and previous imprisonment among the husbands. Netherless, both husbands and wives had wide range of educational achievements. Mmost wives were subjected to repeated violence because they had no alternative but to return to the marital home; There was an association between wife battering and child abuse. Places of sanctuary are needed where a woman can take her children when violence is out of control.*Br Med J* 1975; 1 doi: http://dx.doi.org/10.1136/bmj.1.5951.194 (Published 25 January 1975)Cite this as: Br Med J 1975;1:194

Psychopathology:

Depression:

Overall, the mean depression score was found to be 19.63 indicating that in the present study, battered women showed presence of moderate depression (range 19-29 indicates moderate depression). It could be possibly reasoned that the battered women suppresses their negative feelings and emotions related to the abuse. The various feelings experienced by the battered women are pain, despair, destitute, sadness and solitude. Intimate partner violence (IPV) is a well recognized public health issue. According to the U.S. Centers for Disease Control (1998)and Prevention, IPV is defined as:“physical and/or sexual violence, or threats of such violence, or psychological/ emotional abuse including coercive tactics; between persons who are current or former spouses, marital or non-marital partners, same or opposite sex partners

and boyfriend/girlfriends or dating partners. They may be co-habiting, but need not be." (Saltzman, 1999)In the past two decades, there has been a rapid increase in the awareness of IPV and the incidents of IPV reported in different countries. In 2002, the issue was raised at the international level by the World Health Organization (WHO) in its first report on health and violence against women (Krug, 2002). According to the report, the lifetime prevalence of physical assaults by intimate partners against women was between 10 and 69 percent among 48 population-based surveys worldwide (Krug, 2002).

Anxiety:

Mean scores on Hamilton Anxiety score was found to be 16.70 indicating presence of mild anxiety symptoms (range 0-18 indicates mild anxiety) in battered women, which is indicative of fearfulness in engaging and maintaining intimate relations with the abusive partner, leading to loss of trust and respect. The study also shows that battered women exhibits physiological symptoms like frequent sweating, palpitations and nervousness. Similar studies showsDespite of the seriousness of the problem in terms of violation of human rights and public health consequences, there is a dearth of knowledge on the magnitude and nature of violence against women for various reasons. Of them methodological difficulties in studying the problem are the important ones (Bhuiyaet al., 2003). The magnitude of the problem is also clouded by the fact that domestic violence is a crime that is under recorded and under-reported. On the other hand, shame, fear of reprisal, lack of information about legal rights, lack of confidence in,or fear of, the legal system, and the legal costs involved make women reluctant to report incidents of violence. In Tripura, Tripura Commission for Women tries to unearth various aspects related to violence against women. However no such study has been carried out here to reveal the mental health status of the victim women.(Bhuiyaet al., 2003).

Stress:

In the present study, the average score on stress questionnaire was found to be 192.73 indicating presence of mild stress (range 150-200 indicates mild stress) in battered women recruited in the present studyOther forms of emotional distress accompany stress, particularly depression and dysthymia, are noted among domestic violence victims. A history of depression may be a risk factor for victimization. Suicide is a risk among domestic violence victims who exhibit PTSD symptoms. PTSD may mediate the link between partner abuse and

suicidal ideation. Substance abuse was reported in a high percentage of victimized women. Women who reported being victims of child abuse and adult abuse had significantly more lifetime drug and alcohol dependence than women not reporting abuse. In addition to PTSD, stress, depression, and substance abuse, other mental health problems have been noted in victimized women. The empirical evidence does suggest that younger unemployed women, with are latively large number of children, with low income, and low levels of social support, are more at risk to experiencing PTSD symptoms and other mental health problems than women without those characteristics. (Walker,1984).

PTSD:

On the scale of PTSD, the battered women scored an average of 22.43 indicating presence of no significant PTSD symptoms in the sample. Despite of marital discord, the battered women in the present women showed insignificant level of distress because they tend to distract and engage themselves into household chores, meeting support groups and seeking security within their maternal family. Available research indicates that the symptoms exhibited by battered women are consistent with the major indicators of PTSD as currently defined by the DSM IV. A consistent finding across varied samples (i.e., clinical samples, shelters, hospitals, community agencies, etc.) is that substantial proportions of victimized women (31% to 84%) exhibit PTSD symptoms. The domestic violence shelter population is at a higher risk for PTSD than victimized women who are not in shelters. Estimates of victimization among the shelter population range from40% to 84%.Having multiple victimization experiences (childhood abuse, particularly sexual abuse, and adult sexual abuse) increases the likelihood of PTSD and many other types of psychiatric disorders. The extent, severity, and type of abuse are associated with the intensity of PTSD. Severity refers to how life threatening the abuse is. The more life threatening the abuse is, the more traumatic the impact. Sexual abuse, severe physical abuse, and psychological abuse are associated with an increase in trauma symptoms among victims. Women need not experience Severe violence to experience PTSD symptoms; but experiencing severe violence exacerbates Symptoms. Psychological abuse may be as damaging as physical. (Walker,1984)

Overall, it was seen that in the present study, the battered women experienced more depression compared to stress, anxiety and PTSD.

Emotional intelligence:

The overall mean emotional intelligence was found to be 339.70 indicating no significant difficulty in understanding and expression of emotions of self and others. The specific scores on the emotional intelligence scale also reiterates that the battered women in the present study were well aware of their emotions (M=63.47) and exerted self control in order to safeguard their marriages (M=56.40). It was also found that the battered women are empathetic (M=53.43) and motivated (M=58.83)in order to handle emotions of self and others (M=53.13) indicating that despite of the history of abuse, battered women are able to modulate and regularise their emotions by distracting themselves and being socially responsible. In general, women in India since the attainment of the age of marriage are verbalized about marital life and its maintenance and motivated to maintain it. Similar studies have been found that Spousal emotional abuse is a significant problem, with approximately 35% of women reporting such abuse from a spouse or romantic partner (O'Leary, 1999); in addition, women often demonstrate negative psychological outcomes long after this abuse.

Despite the frequent calls for efficacious therapies for these women, no empirically validated treatments have been clearly established (Enns, Campbell, & Courtois, 1997; Mancoske, Standifer, & Cauley, 1994; Miller, Veltkamp, & Kraus, 1997; Paul,2004), and the literature still demonstrates a focus on the definition of and screening for spousal emotional abuse rather than empirical testing of therapeutic strategies (Follingstad, 2000; Gondolf, Heckert,& Kimmel, 2002; Tjaden, 2004).Spousal psychological abuse represents a painful betrayal of trust, leading to serious negative psychological outcomes for the abused partner (Dutton & Painter, 1993; Sackett & Saunders,1999). According to Sackett and Saunders (1999), spousal psychological abuse functions with the purpose of causing emotional pain to the spouse and establishing an unequal distribution of power in the relationship. Sackett and

Saunders (1999) has demonstrated negative outcomes of emotional abuse that are distinct from the impact of physical battery. Follingstad, Rutledge, Berg, Hause, and Polek(1990) and Sackett and Saunders (1999) have identified at least seven categories of spousal psychological abuse: criticizing, ridiculing, jealous control, purposeful ignoring, threats of abandonment, threats of harm, and damage to personal property, with ridicule associated most strongly with negative outcomes of psychological abuse.

Coping strategies:

The present study found that battered women engaged more into escape-avoidance style of coping (M=17.50) compared to other styles of coping indicating that the battered women do not directly deal with the stressful situation and try to protect themselves from psychological damage. In the present study, it was consistently found that the battered women experienced mild levels of stress and anxiety because they tend to employ distraction techniques such as listening to music, hoping that a miracle would happen, seeking social support, taking drugs, engaging into household chores etc which helps them to avoid the situation and keep themselves inhibited from expression of emotions. Another potential reason could be that the battered women undergo fear of rejection and thus display withdrawal behaviours. The abuse of women in intimate relationships is a serious national public health problem. Approximately 1.5 million women are physically assaulted and/or raped by an intimate male partner in the United States annually (Centers for Disease Control and Prevention, 2003). These assaults are associated not only with direct (fatal and nonfatal) injuries and physical health problems but also with a range of psychosocial and mental health problems (Campbell,2002; Koss, 1990). Although coping and the recovery environment are thought to be critical for the psychosocial adjustment of battered women (Carlson, 1997; Sullivan & By bee, 1999),

Self controlling –interpersonal problem, tolerate stress. The present study indicates that majority of who have been battered indulged in to the self controlling type of coping, and adjust with their environment make attempt facilitate and improve their interpersonal problem. Similar studies have been found that the coping strategies that a victim of a rape engages in can have a strong impact on the development and persistence of psychological symptoms. Research provides evidence that victims who rely heavily on avoidance strategies, such as suppression, are less likely to recover successfully than those who rely less heavily on these strategies. The present study utilized structural path analysis to identify predictors of avoidance coping following rape and examined factors in the assault itself (e.g., force, alcohol use), sequelae of the assault (e.g., self-blame, loss of self-worth), and social support as potential direct and indirect predictors of avoidance coping. From a sample of 1,253 university women, the responses of 216 women who endorsed an experience of rape were examined. Results suggested that sequelae of the assault such as feelings of self-blame and

negative reactions received from others are potentially important predictors of avoidance coping. Implications of the results for future rape recovery research are discussed.

Seeking social support: The present study indicates that most of the women had used social support as a coping strategy, deal with there stressor. This shows that battered women activity attempts to accommodate themselves in various social and group activities, Facilitating catharsis and disengagement from the traumatic event. I.e. Physical abuse and intimate partner violence (M=10.77) Similar studies on domestic violence and help-seeking behaviors of women living in rural communities has been limited. This study adds to existing knowledge by examining this type of violence along with mental health characteristics and related help-seeking behaviors of a sample of predominantly Hispanic women seeking shelter at a rural domestic violence shelter. Study participants experienced physical, verbal, emotional, and sexual abuse, harassment, stalking, and abuse with a weapon in their current intimate relationship. Twenty-four percent of study participants of Hispanic backgrounds and 10% of participants from all other racial/ethnic groups reported experiencing all types of abuse listed above. When compared with other study participants, a greater percentage of Hispanic participants indicated that they had thought of and/or attempted suicide. Participants' help-seeking behaviors from formal support systems suggest a mismatch between the types of abuse experienced and the resultant help-seeking behaviors they used. These help-seeking behaviors also indicate the relevance of mental health characteristics (e.g., suicide ideation) in these behaviors. These and findings from other studies may provide the impetus for a systematic documentation of domestic violence and help-seeking behaviors of women living in rural communities.(Krishnan, Satya, Hilbert, Judith; VanLeeuwen, Dawn, 2001).

CONCLUSION:

Aim of the study was to assess the level of psychopathology, emotional intelligence experienced by battered women and the various coping strategies employed to deal with them. The present study clearly showed that majority of women, were housewives residing in joint family and dependent on their partner had under gone intimate partner violence moderate level of depression. Even though the battered women had high emotional intelligence they were unable to adopt and practically use active coping strategies such as confrontive, positive distraction coping strategies to deal with their daily stressors. However, in this study, no significant correlations were found between any variables under study.

LIMITATIONS:

Following limitations have been identified in the present study:

- Small Sample size(N=30).
- Time lapse of intimate partner violence was short (3 months)
- Unavailability of partner to corroborate the information obtained.

FUTURE DIRECTION:

- Sample can be recruited from urban, semi-urban and rural
- Cross sectional study involving time lapse violence and presence of psycho pathology.
- Psychotherapeutic intervention could be provided, as therapy.
- Exploring the types of intimate partner violence and its effect on battered women can be studied.

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Appendix-A Consent Form For the Purpose of M. Phil Dissertation

"Psychopathology, Coping strategy and Emotional Intelligence of Battered Women Syndrome"

Basic Information to be given to the Participants

I, Priyajadav am currently pursuing my M.Phil degree in Clinical Psychology from Gujarat Forensic University, Gandhinagar. As part of my course work I am conducting a research on the**. Psychopathology, Coping strategy and Emotional Intelligence among Battered Women Syndrome"**As part of the research, you will be provided with six rating scales and the assessment will approximately take 30-40 minutes. From the given alternatives, choose the one that suits your response. The test results shall be kept entirely confidential. The decision to participate or not to is entirely in your hands.

પ્રાથમિક માહિતી:

હું, Priya Jadav એમ. ફિલ. ફોરેન્સિક સાયકોલોજીની વિદ્યાર્થી, ગુજરાત ફોરેન્સિક સાયન્સ યુનિવર્સિટીમાં અભ્યાસ કરૂ છું. હું "**Psychopathology, Coping strategy and Emotional Intelligence among Battered Women Syndrome"**ઉપર રીસર્ચકરી રહું છું.આ રિસર્ચકરવા, તમારે તમને પુછવામાં આવેલ બધા પ્રશ્નોના જવાબ આપવા ન રહેશે. આપેલ વિકલ્પોમાંથી તમને જે વિકલ્પ વધુ અનુકૂળ લાગે તેના માટે સહમતિ આપો. આપના તરફથી સહકાર અને સાચ જવાબની અપેક્ષા રાખી એ છીએ. તમારા વિષેની સમ્પૂર્ણ માહિતી ગુપ્ત રાખવામાં આવશે. આ રિસર્ચના પરિણામો જાહેર થઇ શકે છે પરંતુ તમારી ઓળખ ગુપ્ત રાખવામાં આવશે. આ રિસર્ચમાં ભાગ લેવો કે ન લેવો એ નિર્ણય આપને રહેશે.

Participant's Consent

I confirm that I have read the above explained study and understood the information provided. I know that my participation is voluntary and that I am free to withdraw at any time without giving a reason. I agree to take part in the present study.

"હું આ રિસર્ચકરવા ના કારણે જાણું છું અને એમ ભાગ લેવા પણ તૈયાર છું. હું જાણું છું કે મારા વિષેની બધી જ માહિતી ગુપ્ત રાખવામાં આવશે. હું કોઇપણ સમયે કોઇપણ કારણ આપ્યા વિના સન્શોધન કાર્ય અધવચ્ચેથી જઇ શકું છું"

Name of Participant Date

_____

Name of the Researcher Date

APPENDIX-B SOCIODEMOGRAPHIC DETAIL SHEET

DATE:

Name:

Age:

Sex: Female

Education: 5^{th}-8^{th}, 9^{th}-12^{th}, Graduate, Post-Graduate

Occupation:

Marital Status: Married/Divorce

Domicile: Urban/Rural

Socioeconomic Status: Lower/Middle/Upper

Duration of Illness:

Family Type: Nuclear/Joint/Separate

Family History of Mental Illness: Present/ Absent

Age of Onset

APPENDIX-C Beck Depression Inventory

Beck's Depression Inventory

1.

0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.

0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.

0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.

0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.

0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.

0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.

1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I have almost no interest in sex.
3. I have lost interest in sex completely.

APPENDIX-D Marital Adjustment Rating Scale

1. Check the dot on the scale line below which best describes the degree of happiness, everything considered, of your present marriage. The middle point, "happy," represents the degree of happiness which most people get from marriage, and the scale gradually ranges on one side to those few who are very unhappy in marriage, and on the other, to those few who experience extreme joy or felicity in marriage.

0	2	7	15	20	25	35
.	.	.	.	.	.	.
Very Unhappy			Happy			Perfectly Happy

State the approximate extent of agreement or disagreement between you and your mate on the following items.

	Always Agree	Almost Always Agree	Occasionally Disagree	Frequently Disagree	Almost Always Disagree	Always Disagree
2. Handling Family Finances	5	4	3	2	1	0
3. Matters of Recreation	5	4	3	2	1	0
4. Demonstration of Affection	8	6	4	2	1	0
5. Friends	5	4	3	2	1	0
6. Sex Relations	15	12	9	4	1	0
7. Conventionality (right, good, or proper conduct)	5	4	3	2	1	0
8. Philosophy of Life	5	4	3	2	1	0
9. Ways of dealing with in-laws	5	4	3	2	1	0

10. When disagreements arise, they usually result in:

husband giving in: 0 wife giving in: 2 agreement by mutual give and take: 10

11. Do you and your mate engage in outside interests together?

All of them: 10 some of them: 8 very few of them: 3 none of them: 0

12. In leisure time do you generally prefer:

to be "on the go" to stay at home Does your mate generally prefer:

to be "on the go" to stay at home ?

(Stay at home for both, 10 points; "on the go" for both, 3 points; disagreement, 2 points.)

13. Do you ever wish you had not married?

Frequently: 0 occasionally: 3 rarely: 8 never: 15

14. If you had your life to live over, do you think you would:

Marry the same person: 15 marry a different person: 0 not marry at all: 1

15. Do you confide in your mate?

Almost never: 0 rarely: 2 in most things: 10 in everything: 10

APPENDIX-E Ways of Coping Scale

Not Used-0, Used Somewhat-1,Used Quite A Bit-2, Used A great deal-3

1. Just concentrated on what I had to do next – the next step.
2. I tried to analyze the problem in order to understand it better.
3. Turned to work or substitute activity to take my mind off things.
4. I felt that time would make a difference – the only thing to do was to wait.
5. Bargained or compromised to get something positive from the situation.
6. I did something which I didn't think would work, but at least I was doing something.
7. Tried to get the person responsible to change his or her mind.
8. Talked to someone to find out more about the situation
9. Criticized or lectured myself.
10. Tried not to burn my bridges, but leave things open somewhat
11. Hoped a miracle would happen.
12. Went along with fate; sometimes I just have bad luck.
13. Went on as if nothing had happened.
14. I tried to keep my feelings to myself.
15. Looked for the silver lining, so to speak; tried to look on the bright side of things
16. Slept more than usual.
17. I expressed anger to the person(s) who caused the problem.
18. Accepted sympathy and understanding from someone.
19. I told myself things that helped me to feel better.
20. I was inspired to do something creative.
21. Tried to forget the whole thing.
22. I got professional help
23. Changed or grew as a person in a good way.
24. I waited to see what would happen before doing anything.
25. I apologized or did something to make up.
26. I made a plan of action and followed it.
27. I accepted the next best thing to what I wanted.
28. I let my feelings out somehow.
29. Realized I brought the problem on myself.
30. I came out of the experience better than when I went in.
31. Talked to someone who could do something concrete about the problem.
32. Got away from it for a while; tried to rest or take a vacation.
33. Tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.
34. Took a big chance or did something very risky.
35. I tried not to act too hastily or follow my first hunch.
36. Found new faith.
37. Maintained my pride and kept a stiff upper lip.
38. Rediscovered what is important in life.
39. Changed something so things would turn out all right.
40. Avoided being with people in general.

41. Didn't let it get to me; refused to think too much about it.
42. I asked a relative or friend I respected for advice.
43. Kept others from knowing how bad things were.
44. Made light of the situation; refused to get too serious about it.
45. Talked to someone about how I was feeling.
46. Stood my ground and fought for what I wanted.
47. Took it out on other people.
48. Drew on my past experiences; I was in a similar situation before.
49. I knew what had to be done, so I doubled my efforts to make things work.
50. Refused to believe that it had happened.
51. I made a promise to myself that things would be different next time.
52. Came up with a couple of different solutions to the problem.
53. Accepted it, since nothing could be done.
54. I tried to keep my feelings from interfering with other things too much.
55. Wished that I could change what had happened or how I felt.
56. I changed something about myself.
57. I daydreamed or imagined a better time or place than the one I was in.
58. Wished that the situation would go away or somehow be over with.
59. Had fantasies or wishes about how things might turn out.
60. I prayed.
61. I prepared myself for the worst.
62. I went over in my mind what I would say or do.
63. I thought about how a person I admire would handle this situation and used that as a model.
64. I tried to see things from the other person's point of view.
65. I reminded myself how much worse things could be.
66. I jogged or exercised.

APPENDIX-F Emotional Intelligence Rating Scale

Emotional Intelligence Scale (CRM)

Following are statements that describe the mental states, responses, and actions, of persons during different life situations. You may find each condition applicable to you in different degrees. Mark your responses using the following categories that show their applicability for you.

1 - Never, 2 - Rarely, 3 - Sometimes, 4 - Usually, 5 - Always.

Name/Code: Age: Date:

		1	2	3	4	5
1	I often feel guilty that I could have done better even when I perform well.					
2	Though it is an unpleasant task, I review my performance so that I can identify my shortcomings.					
3	I often fail in my assignments mainly because others who should have helped me did not care.					
4	My success in job is only because of the grace of God / as decided by my destiny.					
5	Looking at my own performance, I feel poorly about my skills.					
6	Looking at my own performance, I feel poorly about my ability to deal with others.					
7	I have made important decisions when I was upset, angry, or elated.					
8	I shout at others when I am impatient or angry.					
9	When someone snaps at me, I panic					
10	I am unable to delay an action even if I think it is not yet time to act.					
11	I often buy things first and only then think of how it would affect my economy.					
12	Whenever I pursue an action plan, it is because I am personally convinced of its purpose.					
13	If a friend is in trouble because of an action committed by him or her, I will try to understand his/her point of view before holding him responsible for the action.					
14	When someone snaps at me, I withdraw feeling hurt.					
15	When there is disagreement with a person, I fail to reason out, but I flare up in anger.					
16	When there is disagreement, I become anxious suddenly without any apparent reason.					
17	I can express my disapproval in a cool manner.					
18	I often find myself helping others handle their emotional difficulties.					
19	I can suppress the expression of my emotion, if I want to.					
20	When some one snaps at me, I start crying					
21	I prefer not to let others know my feelings.					
22	I make effort to understand how others feel before I let them know my dissent					

	to their actions.					
23	I consider that understanding how others feel is important for one to make others understand own feelings.					
		1	2	3	4	5
24	I constantly feel the need for praise, acceptance, and being wanted.					
25	I feel uncomfortable when others are emotional.					
26	I avoid friends, who are intensely emotional.					
27	I feel that there is no need to feel concerned about others' emotions.					
28	I consider that I often over-react to any situation.					
29	I become considerate to others when I see that they are upset.					
30	When someone snaps at me, I quickly retaliate.					
31	Others often come to me for solace and compassion					
32	When someone snaps at me, I insist on an explanation.					
33	When I am hurt, I try to share and discuss the matter with friends and/or relatives.					
34	When I am hurt, I blow my top.					
35	When I break a rule, I show anger and disappointment by shouting at others.					
36	When I break a rule, I feel bad but get over it soon.					
37	I am considered a good listener.					
38	When I break a rule, I do not allow myself to feel bad.					
39	When I start working on a job, I feel excited about doing it and its prospects.					
40	I feel that my goals are beyond the reach of my abilities and skills.					
41	I feel that I have set a lower goal because I am not confident in myself.					
42	I feel secure to execute an action plan approved by others rather than by my personal conviction.					
43	I know when I am angry or upset.					
44	I often talk myself out of anger.					
45	I do not mind even if I am not praised for the work I have accomplished well.					
46	If I set my mind on getting something, I go for it straight away at all costs.					
47	I believe in living in the present.					
48	I like to introspect.					
49	I consider that I always under-react to any situation.					
50	I always speak out my mind, even if it hurts others.					

Appendix-G Post Traumatic Stress Disorder Rating Scale

PTSD Check List – Civilian Version (PCL-C)

Client's Name: _____

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

No. Response

1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?
2. Repeated, disturbing dreams of a stressful experience from the past?
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?
4. Feeling very upset when something reminded you of a stressful experience from the past?
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?
6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?
7. Avoid activities or situations because they remind you of a stressful experience from the past?
8. Trouble remembering important parts of a stressful experience from the past?
9. Loss of interest in things that you used to enjoy?
10. Feeling distant or cut off from other people?
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?
12. Feeling as if your future will somehow be cut short?
13. Trouble falling or staying asleep?
14. Feeling irritable or having angry outbursts?
15. Having difficulty concentrating?
16. Being "super alert" or watchful on guard?
17. Feeling jumpy or easily startled?

APPENDIX-H Hamilton Anxiety Rating Scale

0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.
1 Anxious mood 01 234
2 Tension 01 234
3 Fears 01 234
4 Insomnia 01 234
4 Insomnia 01 234
5 Intellectual 01 234
6 Depressed mood 01 234
7 Somatic (muscular) 01 234
8 Somatic (sensory) 01 234
9 Cardiovascular symptoms 01 234
10 Respiratory symptoms 01 234
11 Gastrointestinal symptoms 01 234
12 Genitourinary symptoms 01 234
13 Autonomic symptoms 01 234
14 Behavior at interview 01 234

APPENDIX-I Stress Rating Scale

Adults

To measure stress according to the Holmes and Rahe Stress Scale, the numbers of "Life Change Units" that apply to events in the past year of an individual's life are added and the final score will give a rough estimate of how stress affects health.

Life event	Life change units
Death of a spouse	100
Divorce	73
Marital separation	65
Imprisonment	63
Death of a close family member	63
Personal injury or illness	53
Marriage	50
Dismissal from work	47
Marital reconciliation	45
Retirement	45
Change in health of family member	44
Pregnancy	40
Sexual difficulties	39
Gain a new family member	39
Business readjustment	39
Change in financial state	38
Death of a close friend	37
Change to different line of work	36
Change in frequency of arguments	35
Major mortgage	32
Foreclosure of mortgage or loan	30
Change in responsibilities at work	29
Child leaving home	29
Trouble with in-laws	29
Outstanding personal achievement	28
Spouse starts or stops work	26
Beginning or end school	26
Change in living conditions	25
Revision of personal habits	24
Trouble with boss	23
Change in working hours or conditions	20
Change in residence	20
Change in schools	20
Change in recreation	19
Change in church activities	19
Change in social activities	18
Minor mortgage or loan	17
Change in sleeping habits	16
Change in number of family reunions	15
Change in eating habits	15
Vacation	13
Major Holiday	12
Minor violation of law	11

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